Individual Support Plan

I. Essential Information

Contact Information

Legal Name:	**Sarah Gwen Baker**	**Preferred Name:**	**Sarah**
Date of Birth:	**06/22/64**	**Gender:**	**F**
Medicaid #:	**990012228775**	**Medicare #:**	**231-09-0045**
Home Street Address:	**8441 Vida Lane**	**Insurance:**	**Vital Insurance 2310045**
Mailing Address or P.O. Box:	**N/A**	**SSN#:**	**231-09-0045**
City:	**Vida, VA**	**Zip Code:**	**26698**
Home phone:	**703-998-7723**	**Cell phone:**	**N/A**
Work phone:	**N/A**	**Email address:**	**N/A**

Emergency Contacts / Representation

Name	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Legal Guardian:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Authorized Rep:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Family #1: Glen Baker	**Phone:** **703-663-8585**	**Fax:**	**Email: glenb@email.org**
Relationship: brother	**Address**: 65 Carter Road Vida, VA 24998		
Family #2: Addie Haines	**Phone:** **703-334-0908**	**Fax:**	**Email: AddieH@email.org**
Relationship: sister	**Address**: 988 Victoria Circle Wetbrook, CT 69887		
Family #3: Melinda Baker	**Phone:** **703-334-0908**	**Fax:**	**Email:**
Relationship: Mother	**Address**: 988 Victoria Circle Wetbrook, CT 69887		
Power of Attorney:	**Phone:**	**Fax:**	**Email:**
Relationship/Type:	**Address**:		
Emergency Contact:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Conservator:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		

Representative Payee: Vida Residential	**Phone: 703-998-7723**	**Fax: 703-998-7724**	**Email: VidaGH@email.net**
Relationship: Provider	**Address**: **8441 Vida Lane VA 24998**		
Physician 1: Dr. Huffman	**Phone: 703-663-8585**	**Fax: 703-663-8585**	**Email:**
Specialty: PCP	**Address**: 1233 East Sparrow Road Vida, VA 26985		
Physician 2:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Physician 3:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Physician 4:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Dentist: Gary Burgess	**Phone: 703-988-9342**	**Fax: 703-988-0900**	**Email:**
Address:2232 Dell Road			
Other:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Other:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		

Support Coordination and Provider Contacts

Support Role: SC	**Agency: Vida CSB**	
Name: Grace Givens		**Address:3344 Conway Road Vida, VA 24998**
Phone:703-889-5656	**Fax:703-887-3698**	**Email:gg@email.com**
Support Role: DSS Eligibility	**Agency: Vida DSS**	
Name: Martha Johns		**Address:1265 Valley Drive Vida, VA 24998**
Phone:703-833-0058	**Fax:703-833-6658**	**Email:mj@dss.gov**
Support Role: Residential	**Agency: Vida Residential**	
Name: Martin Green		**Address:8441 Vida Lane VA 24998**
Phone:703-998-7723	**Fax:703-998-7724**	**Email:VidaGH@email.net**
Support Role: Day support	**Agency: Vida Day**	
Name: Jill Glover		**Address:980 Massey Lane Vida, VA 24998**
Phone:703-886-9987	**Fax:703-998-7724**	**Email:VidaDay@email.net**
Support Role: Companion	**Agency: Companions, Inc.**	
Name: Dottie Hodges		**Address:5536 2nd Street Vida, VA 24998**
Phone:703-989-3696	**Fax:703-989-3697**	**Email:dottieh@email.net**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**

Communication and Sensory Support

Preferred language:	Please *check one*) ☒ English ☐ Spanish ☐ Vietnamese ☐ Other (Please Specify):
Describe supports needed for communication (if any):	Sarah is able to communicate through spoken English. Sometimes it takes her a moment to form her statements, which usually happens when she is nervous or excited. After a moment, she begins sharing her ideas and thoughts.
Do I have any difficulty reading a magazine or newspaper?	☒ Yes ☐ No If *yes*, please describe. Sarah can recognize a few words in print and needs support understanding printed text.
Would a professional evaluation related to sensory or communication abilities be beneficial?	☐ Yes ☒ No

Adaptive Equipment, Assistive Technology and Modifications

Please describe any adaptive equipment and assistive technology supports (if any):	Sarah uses a wheelchair with a lap belt and an adaptive device for personal care in the restroom.
Would a professional evaluation related to adaptive equipment, assistive technology or other modifications be beneficial?	☐ Yes ☒ No

Health Information

Advanced Directive	
Do you have an advanced directive?	☐ Yes ☒ No If yes, please provide a copy to all relevant parties.

Medication:	**Physician:**		**Reason(s) prescribed:**
Dosage:	**Route:**	**Frequency:**	**Location of potential side effect information:**
1:Carbamazepine	**Huffman**		**Seizures**
800mg	**PO**	**BID**	**all provider records**
2:			
3:			
4:			
5:			

6:		
7:		
8:		
9:		
10:		

HEALTH TOPIC	**DESCRIPTON**
Date of my last complete physical exam.	Date:11/14/07
Date of my last dental exam.	Date:11/16/07
Do I have any mental health support needs?	☐ Yes ☒ No If *yes*, please describe:
Do I have any allergies to medication, food, or environmental elements (e.g., mold, dust, etc.)?	☒ Yes ☐ No If yes, please describe: Prednisone
Please describe all recent physical complaints & medical conditions.	Sarah has a seizure disorder and averages approximatley 2 seizures month. She also has type 2 diabetes and is at risk for falling without her lap belt fastened. She tested negative for TB at her last physical in November.
Do I have any issues with physical intimacy, pregnancy or child rearing?	☐ Yes ☒ No If *yes*, please describe:
Do I have any chronic health conditions?	☒ Yes ☐ No If *yes*, please describe: Diabetes (type 2), seizure disorder
Do I have any communicable diseases?	☐ Yes ☒ No If *yes*, please describe:
Do I have any limitations or restrictions on physical activities?	☒ Yes ☐ No If *yes*, please describe: lap belt needed during waking hours
Have I had any serious illnesses, serious injuries, and/or hospitalizations in the past?	☒ Yes ☐ No If *yes*, please describe: Sarah was treted for viral meningitis in 1996.
Have there been any serious illnesses or chronic conditions among my parents, siblings, or grandparents?	Mother also has type 2 diabetes.
Have there been any serious illnesses or chronic conditions among significant others in my household (if any)?	
Have I ever smoked cigarettes/cigars or used smokeless tobacco?	☐ Yes ☒ No If *yes*, please describe:
a. How often do I drink alcohol? b. Does my current use of alcohol cause problems in any area of my life?	*a.* Number of times and number of drinks per week: 0 *b.* ☐ Yes ☒ No If *yes*, please describe:
a. Does my current use of prescription medication cause problems in any area of my life?	*[Any benzodiazepine, sedative-hypnotic or narcotic under Medications should trigger an SA evaluation. (b) addresses drug tolerance and possible dependence.]N/A*

b. Have I found that I have to take more and more of any prescription medication to feel an effect?	
Have I ever been in treatment for a problem with, or resulting from, use of alcohol, drugs, or prescription medicine?	.☐ Yes ☒ No If *yes*, please describe *what type of treatment, was provided and when.*
Is there any other health history or medical information or health preferences that I would like to share?	Sarah's mother reports that Sarah is diagnosed with Type 2 diabetes, has a seizure disorder and uses a wheelchair with a lap belt to prevent falls. Sarah checks her blood glucose levels before meals with support and follows a diabetic diet. Sarah's mother states that Sarah had her tonsils out as a young child and underwent surgery for back pain as a young adult. Her mother states that Sarah is not sexually active, has no children, no history of communicable diseases and no history of sexual or physical abuse. Sarah's family has a history of diabetes and heart disorders. Sarah is checked annually by her physician for heart rhythm irregularities due to family history. Sarah has no known history of alcohol or illicit drug use.

Summary of Social/Developmental/Behavioral/Family History

Briefly describe my relevant social, developmental, behavioral and family history.	Sarah's mother reports that Sarah experienced a typical childhood and that she and her brother, Glen, have always been close.. She lived with her mother until 1994, when she began receiving Medicaid Waiver. Since that time, she has lived in Vida Group Home. Sarah's mother states that Sarah has always liked her privacy and wants to do as much for herself as possible. When Sarah does become upset it is usually in loud environments and may include her yelling out loud. Taking a break away from the setting is usually helpful.

Summary of Employment and Educational Background

Education: ☐ None ☐ Elementary ☐ Middle School ☐ Some High School ☒ High School ☐ Vocational ☐Some College ☐ College degree ☐ Some Graduate School ☐ Masters Degree or Higher

Current Employment status: ☒ Unemployed, but want to work ☐ Unemployed, not able to or interested in work ☐ Employed, Part-Time ☐ Employed, Full-time ☐ Retired

Describe my educational history.	Sarah says that she has not worked in a paid job. Sarah attended North Meriwether Occupational School through her graduation in 1974
Describe my employment history.	N/A

Describe any volunteer activities in which I now am involved or have been involved in the past (if any).	**Note:** Please include the types of things you did, the organization(s) involved, and when you volunteered. Sarah volunteered for the Animal Society in 2006 for three months.

Exceptional Support Needs

Were any support needs identified on the risk assessment? *(If yes, each need must relate to an outcome in the ISP's Desired Outcomes section. Provide any existing plans for exceptional support needs including behavior and/or crisis plans.)*	☒ Yes ☐ No If yes, please provide a description of each support need below: 1) Diabetes Type 2 2) Seizure Disorder 3) Risk of falling 4) 5) Do I meet criteria for high intensity services? ☒ Yes ☐ No

Ability to Access Services and Supports

What concerns do I have about being able to access services and/or supports?	☐ Yes ☒ No If *yes*, please provide a description and a plan to resolve the concern(s):

Legal and Advocacy

Do I have any current legal issues or problems?	☐ Yes ☒ No If *yes,* please describe:
Do I need any legal advice?	☐ Yes ☒ No If *yes*, please describe:
Do I need any support with voting? (Understanding my rights, registering or voting)	☐ Yes ☒ No If *yes*, please provide brief description of how I will be supported:

Back-up and / or Discharge Plan

Am I receiving a Medicaid Home and Community Based Waiver?	☒ Yes ☐ No If *Yes*, please identify which Waiver: ID Waiver; and please describe or attach my back-up plan. Sarah's back up plan is that she receives 24 hour support.

Describe any transition/discharge plans for any services I currently receive (if applicable).	None at this time.

Review or Revision Date: 6/22/08

Essential Information completed by:

Name (print): Grace Givens